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ALCOHOL USE AND ABUSE:

Background Information for Security Personnel

Richards J. Heuer, Jr.

August 1991

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Richards J. Heuer, Jr.

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Preface

Security program regulations provide guidance on factors that are relevant to the conduct of a personnel security investigation. One factor is alcohol use and abuse, a part of the investigatory process since 1953, when the current program was conceived. This study of alcohol use and abuse is the first in a series of studies of behaviors that raise questions about personnel security and suitability. Other studies will deal with financial irresponsibility or malfeasance, compulsive gambling, nonconforming sexual behavior, criminal behavior, and drug abuse. These reports are intended to provide such background information. They are part of the research agenda recommended by the 1985 Stilwell Commission Report, *Keeping the Nation's Secrets*, a Report to the Secretary of Defense by the Commission to Review DOD Security Policies and Practices.

Investigators, polygraphers, adjudicators and managers involved in the security process need a good perspective on what behavior is going on in society as a whole, what is common, what is uncommon, and what are the indicators that a problem may be either more serious or less serious than appears on the surface. Individual managers and supervisors must judge the significance of this information for their activities and to communicate appropriate guidance to their personnel. The report can aid a training program and will also be helpful to counselors in employee assistance programs.

This report was prepared by the Central Intelligence Agency using the support facilities and assistance of the Defense Personnel Security Research and Education Center (PERSEREC), and it is being disseminated by both organizations. The report has been reviewed for technical accuracy by professionals active in the field of alcohol abuse.

Roger P. Denk
Director

ALCOHOL USE AND ABUSE: Background Information for Security Personnel

Prepared by
Richards J. Heuer, Jr.

Executive Summary

Alcohol abuse is identified in DCID No. 1/14 as one of the behaviors to be considered when adjudicating security clearances. Personnel involved in the security clearance process will be aided by knowledge of the prevalence of alcohol use and abuse in the overall U.S. population, indicators for recognizing alcohol abuse, the relationship between alcohol abuse and other behaviors of security interest, and the effectiveness of treatment for alcohol problems.

About 10% of adult Americans have a serious alcohol problem. Excessive alcohol consumption may impair judgment and increase the risk of accidental, careless or even deliberate disclosure of classified information. The nationwide economic and social cost of lost productivity, accidents and health problems caused by alcohol abuse is estimated at \$136.3 billion per year. These costs are paid, in large measure, by employers.

Motivation for using alcohol or any other drug is one of the most potent predictors of future use or problems with that drug. If the motivation is experimentation, peer pressure, or adolescent rebelliousness, this does not necessarily lead to future abuse. To the extent that alcohol is used as a means of coping with life's problems, such as stress or low self-esteem, then one can expect that the alcohol consumption itself may eventually become a source of future problems. Solitary drinking is far more predictive of future problems than social drinking. So is drinking *prior* to social events (to relax), as compared with alcohol use *at* social events.

A four-question test known as the CAGE questionnaire has been used successfully to identify persons who need a more comprehensive assessment for alcohol problems. The test is so simple that it can be administered inconspicuously during a routine interview.

Arrest for driving while intoxicated (DWI) is one of the most significant indicators of alcohol abuse available to adjudicators. Two studies have shown that 90% of those arrested for DWI have an alcohol problem serious enough to merit treatment. The evidence indicates that most DWI offenders are not average citizens who just happen to be caught during an unusual lapse of judgment or through an unfortunate piece of bad

luck. People who are so drunk that their driving attracts attention and gets them arrested are often problem drinkers. And since problem drinkers drive under the influence repeatedly, they are the ones most likely to be caught.

The child of an alcoholic is several times more likely to become an alcoholic than an individual with no family history of alcoholism. The risk is far greater for children of alcoholic mothers than alcoholic fathers. The child of an alcoholic father is at greater risk if the mother instilled in the child high esteem for the father.

One characteristic of alcohol dependence is increasing tolerance for alcohol--it takes more and more to have the same effect on the body. A claim of high tolerance for alcohol should be interpreted as a warning indicator.

Problems in handling alcohol are often observed in combination with other security and suitability issues, and they take on greater significance in these cases. If alcohol is the only problem, a motivated employee can generally kick the habit or bring it under control so that it does not affect job performance. When combined with other issues, alcohol may be part of a broader pattern of high-risk, irresponsible, or aggressive antisocial behavior that is much harder to change and may justify denial of clearance.

In an Alcoholics Anonymous (AA) membership survey, 42% of those attending AA meetings reported they were also addicted to drugs. Another study found that nearly half of the persons in the general population diagnosed as alcohol abusers or alcohol dependent also had some form of mental or emotional disorder. Soldiers with one DWI offense were found to be several times more likely to be arrested for a criminal offense than those with no prior DWI record. The correlation between alcohol consumption and spouse abuse is so close that researchers have suggested spouse abuse should be regarded as an indicator of alcohol problems.

Successful treatment of alcohol problems depends on the strength of the patient's motivation and compliance with the aftercare program. For those who successfully complete the treatment and aftercare program, the probability of successful work performance is very high. If one gets through the first three months after treatment without relapse, the chances for long-term abstinence improve dramatically, and the chance of relapse that affects work performance is very small. Even without treatment, people often experience remission of alcohol problems as they grow older and the circumstances that prompted the drinking change; this is especially common among women.

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Introduction

Alcohol abuse is one of the criteria that may justify denial of security clearance as specified in Director of Central Intelligence Directive No. 1/14. A recent study analyzed the issues that arose in 7,232 Special Background Investigation cases adjudicated by 14 different federal agencies. The study found that alcohol was the issue in 5% of the cases in which only a single issue was identified. In cases that had three issues, however, alcohol was one of the issues almost 40% of the time.¹ When things go wrong in a person's life, alcohol is often part of the problem.

This study of alcohol use and abuse presents relevant background information for persons engaged in the security clearance process. Most of the information is statistical data that falls into four general categories:

- Statistics on the prevalence of alcohol use and abuse among the U.S. population. The data are broken down according to demographic variables such as age, sex, race/ethnic group, and region when this information is available.
- Potential indicators of alcohol problems. These indicators will help identify those at highest risk for alcohol problems.
- The relationship between alcohol abuse and other problem behaviors. Alcohol abuse is often found in combination with other security and suitability issues. To the extent that alcohol abuse helps identify a pattern of high risk or aggressive, antisocial behavior, it may assume greater importance in these cases.
- Information on treatment effectiveness and relapse rates. This provides background for assessment of mitigating circumstances.

The report is based on a review of relevant literature and pulls together in one place a wide variety of information that may be useful to security policy-makers, practitioners, and researchers. Policy-makers and managers may wish to draw on this information when reviewing standards and procedures. The indicators of alcohol problems may help investigators determine when to expand an investigation. Information on treatment effectiveness and relapse rates may help adjudicators evaluate mitigating factors. References are cited for the benefit of researchers who may wish to delve into some subjects in greater detail.

Some caution is in order when using statistical data about the prevalence of any type of behavior, as such information may be misleading and can be misused.

Statistics that apply to the overall population will generally be different from the frequency rates found in a select and pre-screened pool of persons undergoing security processing. Further, statistical frequency should not be used as the basis for judging the acceptability of behavior. Rather, behavior should be judged on the basis of its relevance to security and work performance, not on the grounds that "lots of people are doing it." Nor should the statistics be used to create stereotypes that bias the investigation against higher risk categories of applicants.

Alcohol Abuse and Personnel Security

Automobile drivers with a blood alcohol content of .08% are four times more likely to be responsible for a fatal accident than drivers who have not been drinking. With a blood alcohol content of .15%, the risk of being responsible for a fatal crash is approximately 25 times greater.² Although comparable statistical evidence is not available for the impact of alcohol abuse on national security, it seems reasonable to assume that high blood alcohol levels also increase the risk of accidental, careless or even deliberate disclosure of classified information.

Alcohol abuse is also closely associated with other behaviors of security concern--crimes against persons and property, financial irresponsibility, personality disorders, drug abuse, and nonconforming sexual behavior. Although alcoholism alone is treatable and not necessarily cause for rejection of a security clearance, it is often part of a broad pattern of high-risk or aggressive antisocial behavior that does mark the undesirable employee.

For example, 42% of members of Alcoholics Anonymous reported they were also addicted to drugs.³ Of drivers who have accidents while driving with suspended, revoked, or no licenses, about 83% have been drinking. Drivers not using seat belts are three times more likely to have been drinking than drivers using seat belts. Intoxicated motorcyclists have been found to wear helmets one-third as often as motorcyclists who are not intoxicated.⁴ The relationship between alcohol abuse and aggressive, antisocial behavior such as crime and spouse abuse is discussed below. When alcohol problems appear together with other undesirable behavior, the combination may add up to more than the sum of its parts.

The economic and social cost of lost productivity, accidents and health problems caused by alcohol abuse raises issues of employee suitability as well as security. The economic cost of alcohol abuse in the United States was estimated at \$116.9 billion in 1983 and was projected to increase to \$136.3 billion in 1990. Of this cost, 61% was attributed to reduced productivity and lost employment and 13% to health care costs and treatment.⁵ It has been estimated that 20% to 40% of all U.S. hospital beds are occupied by persons whose health conditions are complications of alcohol abuse and alcoholism.⁶ These costs are paid, in large measure, by employers.

Alcoholism may also affect mental functioning. Although most alcoholics entering treatment facilities do not have decreased overall intelligence scores, approximately 45% to 70% do have specific deficits in problem solving, abstract thinking, concept shifting, psychomotor performance, and difficult memory tasks. These problems are usually not apparent without neuropsychological testing. The brains of alcoholics have been shown to have structural changes, reduced blood flow, and altered electrical activity. Liver disease and nutritional problems associated with alcoholism may also affect mental functioning.⁷

Prevalence of Alcohol Use and Abuse

A 1990 survey of U.S. households found that 133 million people age 12 and older (66% of the population) drank alcohol during the previous year. Nearly one-third of these, or 42 million, drank at least once a week during the year.⁸ About 10% of adult Americans have a serious problem with alcohol. An estimated 10.5 million adults exhibit some symptoms of alcoholism or alcohol dependence while an additional 7.2 million abuse alcohol.⁹ The terms alcohol dependence and alcohol abuse are used throughout this report. These terms have specific technical meanings.

Alcohol dependence, or alcoholism, is a disease that has four main features:

(1) tolerance, or a state of adaptation in which more and more alcohol is needed to produce desired effects; (2) physical dependence, which means that upon interruption of drinking, a characteristic withdrawal syndrome appears that is relieved by more alcohol (e.g., morning drinking) or other drugs in the sedative group; (3) impaired control over regulating alcohol intake at any drinking occasion once drinking has begun; and, finally, (4) the discomfort of abstinence, or 'craving,' which can lead to relapse.¹⁰

Alcohol abusers are not dependent on alcohol, but they develop difficulties as a result of alcohol consumption and due to poor judgment, failure to understand the risks, or lack of concern about damage to themselves or others. One is diagnosed as an alcohol abuser if one persists in drinking habits that are known to be causing or exacerbating a persistent or recurrent social, occupational, psychological, or health problem; or if one uses alcohol repeatedly under circumstances which are physically dangerous, such as driving while intoxicated. Alcohol abusers are not addicted; they remain in control of their behavior and can change their drinking patterns in response to explanations and warnings.¹¹

The amount of alcohol consumed in the United States is estimated annually by the National Institute on Alcohol Abuse and Alcoholism on the basis of sales in each state as determined from tax receipts, sales in state-controlled stores, and reports from beverage

industry sources. Estimates of average per capita consumption are derived by dividing total sales by the total population age 14 or older.

Following two decades of steady increases, there was a gradual decline in per capital alcohol consumption during the 1980s. Figure 1 shows a significant drop in consumption of hard liquor during the period from 1977 to 1987, a small reduction in beer consumption after 1981, and a consistent increase in the use of wine.¹²

Estimated per capita consumption in 1987 was 2.54 gallons of pure alcohol per person. When abstainers are excluded from the calculation, the estimated consumption per drinker increases to approximately 4 gallons of pure alcohol per person per year. This is equivalent to approximately 89 gallons of beer, 31 gallons of wine, or almost 10 gallons of distilled spirits.¹³

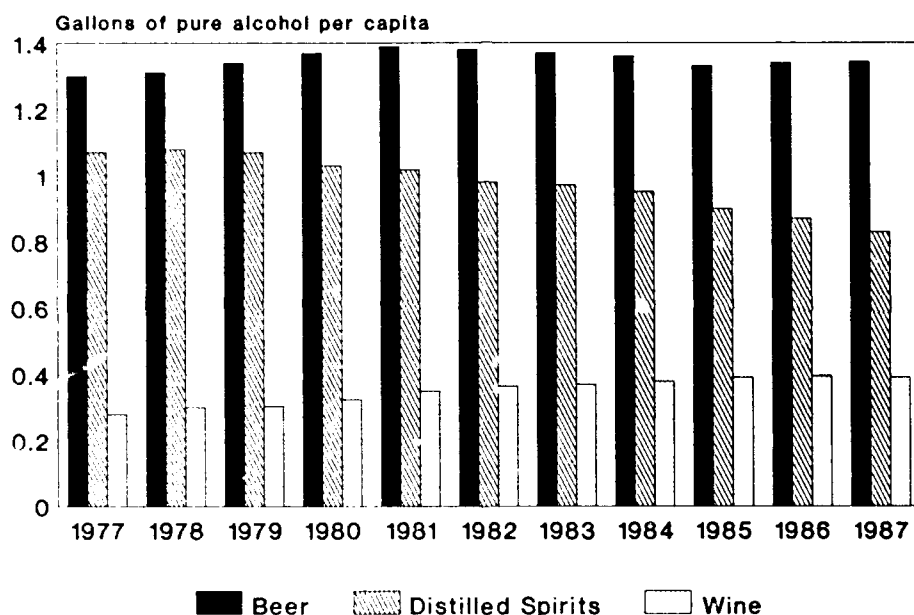


Figure 1. Per Capita Consumption

These averages are deceptive, however, as consumption of alcohol is very unevenly distributed. The 10% of drinkers who drink heavily (6.5% of the total population) account for one-half of all the alcohol consumed. The remaining half is consumed by the 90% who are infrequent, light, or moderate drinkers.

National surveys of drinking patterns show that about one-third of the U.S. population age 18 and over are abstainers, one-third are *light drinkers*, and one-third are moderate to heavy drinkers. In every age group, there are more men than women drinkers, and of those who do drink, a larger percentage of the men than women are heavy drinkers.¹⁴

One of the best sources of data on Americans' drinking habits, broken down by various demographic variables, is the National Household Survey on Drug Abuse sponsored by the National Institute on Drug Abuse of the U.S. Department of Health and Human Services. This survey has been taken every two or three years since 1971. The tenth survey in the series was completed in 1990. This 1990 survey, which is a source for much data in this report, was based on interviews with 9,259 persons age 12 and over selected randomly from the U.S. household population. It is noteworthy that this survey covers only persons living in households; it excludes college students living in dormitories, persons living in military barracks, transients, and those in jail.

Another principal source of data for this report is the *Seventh Special Report to the U.S. Congress on Alcohol and Health* prepared by the National Institute on Alcohol Abuse and Alcoholism, January 1990. These special reports, prepared every three years, describe what has been learned from recent research on alcohol abuse and alcoholism, including many studies that explain or elaborate on the findings of the National Household Survey.

The 1990 survey results document a decline in recent years in the percentage of the population using alcohol. At the time of the 1985 survey, for example, 59% of the survey population had consumed alcohol during the previous month. This dropped to 53% in 1988 and 51% in 1990. Drinking by youth age 12 to 17 has declined steadily since 1979. Drinking by young adults age 18 to 25 has also declined, going from 71% during the previous month in 1985 to 63% in 1990.

This decline may be part of a broader trend toward increased health consciousness. Use rates are declining for tobacco and hard drugs as well as alcohol. Although this broad trend is favorable, there is evidence of an increasing proportion of heavy drinkers among young people in their twenties and a small increase in the prevalence of problems with alcohol dependence.¹⁵

Table 1 examines the percentage of the household population age 12 and over that has consumed alcohol during the past year and breaks this down by age, sex, and frequency of use--at least once, 12 or more times, and once a week or more. It shows that 37% to 38% of males in both the 18-25 and 26-34 age groups, and 15% of the females in these age categories, consumed alcohol at least once a week during the previous year.

Table 1

**Alcohol: Frequency of Use Within Past Year (1990)
by Sex and Age Groups for Total Population**

Age		At Least Once	12 or More Times	Once a Week or More
12-17		41.0%	14.4%	5.1%
	Male	40.8	15.1	5.6
	Female	41.1	13.6	4.5
18-26		80.2	51.1	26.6
	Male	86.0	64.6	38.6
	Female	74.6	38.3	15.0
26-34		78.8	50.8	26.2
	Male	83.1	63.1	37.2
	Female	74.7	38.9	15.5
35+		62.5	37.0	20.1
	Male	68.5	47.3	29.2
	Female	57.2	28.0	12.3
Total		66.0	39.5	20.7
	Male	71.0	49.6	29.7
	Female	61.5	30.1	12.6

Subsequent sections discuss how patterns of alcohol use are affected by demographic variables such as age, sex, race/ethnicity, and region of the country. Alcohol consumption may also be affected by educational level and socioeconomic status, but current data are not available for these variables. Data from the 1985 Household Survey, which did measure educational level, suggests that this may be an important omission. Alcohol consumption does increase as education level increases, so the base rate will be higher in any pool of highly educated applicants than it is in the population at large.

In using these data, the reader needs to exercise caution in drawing conclusions from statistics on frequency of alcohol consumption. Frequency is not the best indicator that an individual has a current drinking problem nor the best predictor of a future drinking problem. Frequency of intoxication is much more significant, but that is difficult to measure accurately in a broad survey, and data directly addressing this variable are not available.

Differences in Age and Sex

Figure 2 shows selected data from Table 1 in a graphical format that highlights the differences between age groups and sex. It shows only the percentage of the household population over 12 that drank alcohol once a week or more during the previous year. Clearly, ages 18 to 34 are the highest usage years, and about two-and-a-half times as many men as women drink this frequently.

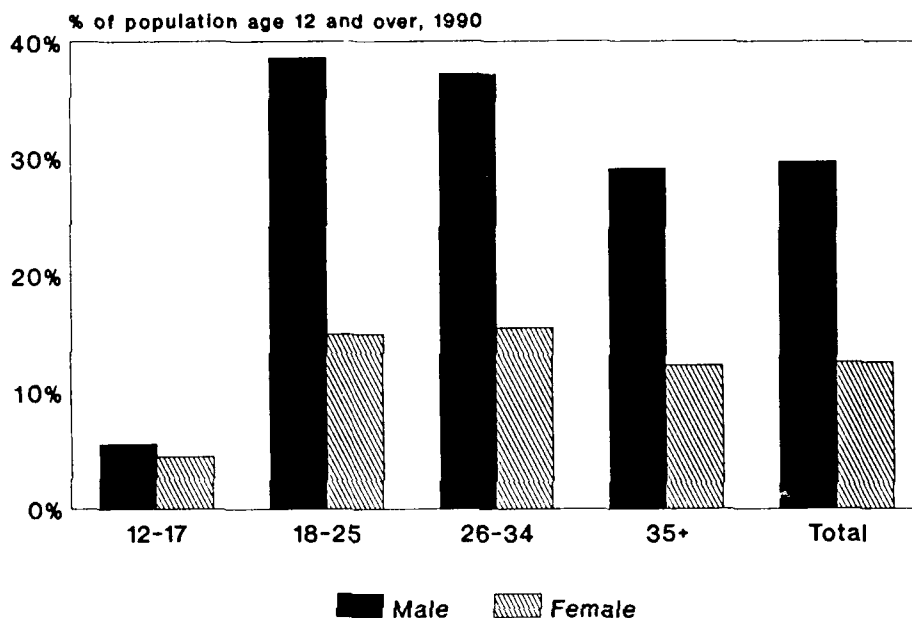


Figure 2. Alcohol Consumption by Age and Sex
Drink at Least Once a Week

The National Household Survey provides an overview, but a number of other studies help fill out the picture. Every year since 1975, the Institute for Social Research at the University of Michigan has conducted a nationwide survey of about 17,000 high school seniors on drug and alcohol use and related questions. This survey confirms significant reductions in frequency and amount of alcohol consumption by high school students since the mid 1980s, but the level remains very high.

In 1987, two-thirds of high school seniors were current drinkers; more than one-third (and nearly half of males) indulged in occasional heavy drinking; nearly one-third did not perceive a great risk in having four or five drinks nearly every day; nearly one-third reported that most or all of their friends

got drunk at least once a week; and nearly 10% had first used alcohol by the sixth grade.¹⁶

Figure 3 shows how these high school drinking practices have changed over the years. Current drinkers are those who consumed alcohol during the previous 30 days, while occasional heavy drinkers took five or more drinks at one sitting during the previous two weeks.¹⁷

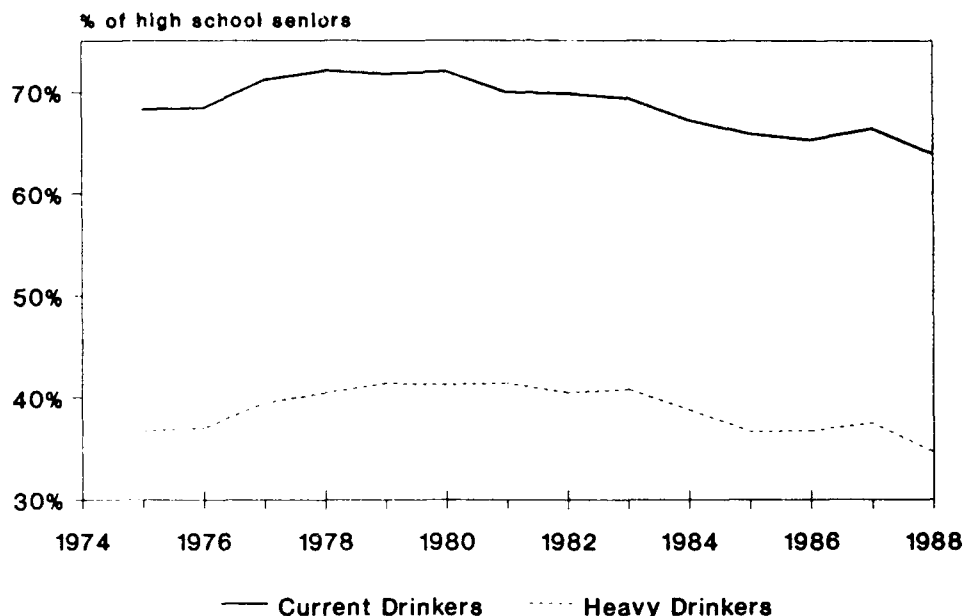


Figure 3. Drinking by High School Seniors

Of particular significance for the security clearance process is that an individual's pattern of drinking in high school does not necessarily remain constant as individuals become older. One study tracked a group of young men over a 15-year period from age 16 to 31. It found that

half of the heavier drinkers at age 18 remained at that level at age 31, and 7% had become abstainers. Half of the 18-year-old abstainers became moderate drinkers, one-third became heavier drinkers, and only 15% remained abstinent. Nearly half of the moderate drinkers became heavier drinkers; most of the other half remained at the same level, except for 4% who became abstainers.¹⁸

Drinking is a problem only if it leads to dependence on alcohol or other adverse consequences. A 1984 national survey found

that 7% of all drinkers had experienced moderate levels of dependence symptoms during the preceding year (i.e., they reported 3 or more of 13 indicators of dependence, such as impairment of control, morning drinking, and increased tolerance). Ten percent had experienced moderate levels of drinking-related consequences (i.e., they reported 4 or more of 32 consequences related to problems with spouse, job, police, or health). As would be expected, many drinkers reported both types of problem, and thus the categories are not mutually exclusive.

Problem levels were higher among men than among women. Among male drinkers, the proportion reporting at least a moderate level of problems was highest in the 18-to-29 age category for both dependence symptoms (14%) and drinking-related consequences (20%). The proportions dropped with increasing age, reaching respective lows of 5% and 7% among men aged 60 and older. Among female drinkers, the proportion reporting at least a moderate level of dependence symptoms remained stable at 5 to 6% from age 18 to age 49 and then dropped to 1%. For drinking-related consequences, however, the proportion reporting at least a moderate level of problems was relatively high in the 18-to-29 age group (12%) but dropped to 6% for women in their thirties and forties and was negligible for women aged 60 and older.¹⁹

The survey respondents most likely to report frequent heavy drinking and problems caused by alcohol were male, young, and single. Frequent heavy drinkers with lower incomes and less education were more likely to report both dependence symptoms and alcohol-related consequences than those at higher income and education levels.

Another study showed some age-related differences between alcohol problems in men and women. The prevalence of drinking problems for men peaks for individuals who are in their 20s. The prevalence declines with age but drinking problems may persist into the 40s and 50s. For women, the problems are more likely to start among those in their 30s but then have a high probability of going away. Women have a much higher rate of remission of alcohol problems than do men at all ages.²⁰

It has been speculated that prevalence of drinking among women has been increasing, leading toward a convergence of drinking patterns between men and women. There is no evidence of this in the surveys, however. There are indications that those women who do drink may be drinking more heavily.²¹ By most measures, women do not drink as heavily as men. In one study, however, the consumption level that defines heavy drinking for females was 25% lower than for males, in order to account for

difference in body weight and thus in blood alcohol level. With this adjustment, the study found very little difference in patterns of heavy drinking between men and women.²²

Although prevalence of drinking among women is much lower than among men, and women have a lower rate of drinking problems, surveys of women's drinking have identified several demographic subgroups where problems are more prevalent.

High-risk groups related to employment included women who were unemployed and looking for work and those who were employed part time outside the home. With respect to marital status, those who were divorced or separated, or who had never married or were unmarried but living with a partner, were at greatest risk. Women in the last category had the highest rates of heavy drinking, drinking problems, and alcohol dependence symptoms of all the employment and marital status groups. Other high-risk groups were women in their twenties and early thirties and women with heavy-drinking husbands or partners.²³

Another study that examined the relationship between alcohol problems and women's changing roles over their life span found that women who were married, had full-time jobs and children at home were the least likely to report drinking problems. Thus it appears that the stresses caused by women's multiple roles do not increase the risk. For women of all ages, the variables of marriage, children, and working full time for pay outside the home or working full time in the home without seeking outside work were associated with less risk of alcohol-related problems. The opposite of these conditions was associated with increased risk of alcohol problems.²⁴

Differences for Race/Ethnicity

Systematic study of drinking by racial and ethnic groups in the United States is relatively recent, so data are not available to draw conclusions about long-term trends. Information is available only on current practices.

Blacks: The 1990 National Household Survey of Drug Abuse reports that, on the whole, blacks drink a little less than whites. There is a significant difference in the distribution of this drinking among age groups. The highest prevalence of drinking among blacks is in the 26-34 age group, as compared with the 18-26 age group for whites. This is illustrated in Figure 4. A 1984 study found a high rate of abstention among blacks in the 18-29 age category, but that rates of heavy drinking rise sharply among those in their thirties.²⁵

This same study determined that black men have somewhat higher abstention rates overall than whites--29% for blacks versus 23% for white men. The differences

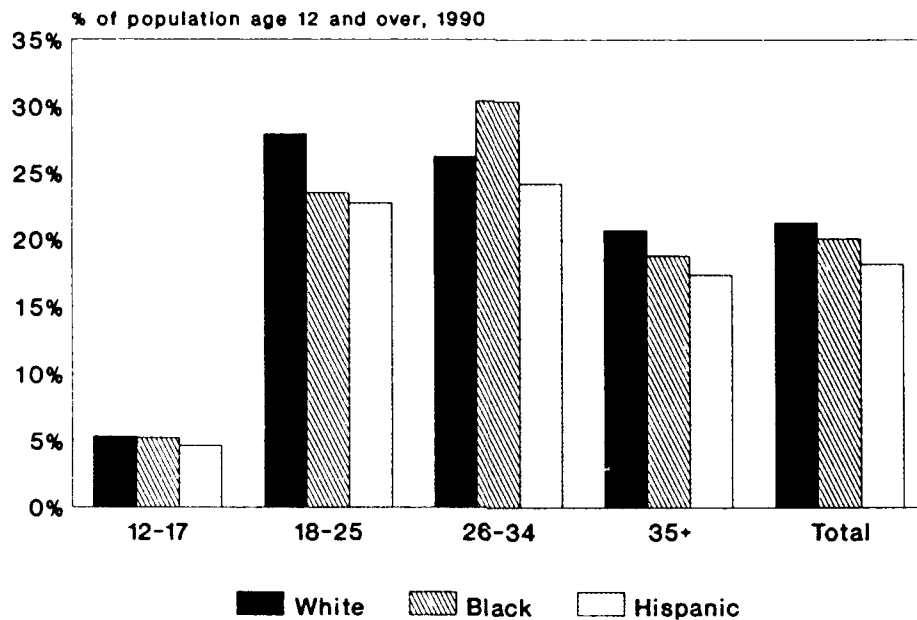


Figure 4. Racial/Ethnic Differences
By Age -- Drink at Least Weekly

were more pronounced among women; 46% of black women abstained compared with 34% of white women.

Although blacks in general drink a little less than whites and have lower rates of heavy drinking, black men report more drinking-related problems than whites. This is principally due to health problems starting with black men in their thirties and continuing throughout middle and old age. Black males who drink heavily for a prolonged period are at extremely high risk for alcohol-related diseases such as cirrhosis, alcoholic fatty liver, hepatitis, heart disease, and cancers of the mouth, larynx, tongue, esophagus and lung.²⁶

Hispanics: The most striking aspect of alcohol consumption by Hispanics is the exceptionally low rate of drinking by Hispanic women. The 1990 U.S. Household Survey found that only 7.5% of Hispanic women drank alcohol at least weekly during the previous year, as shown in Figure 5.

The household survey supports the conclusions of a 1984 study that found 70% of Hispanic women drank either less than once a month or not at all. By contrast, almost the same percentage of Hispanic men were drinkers.

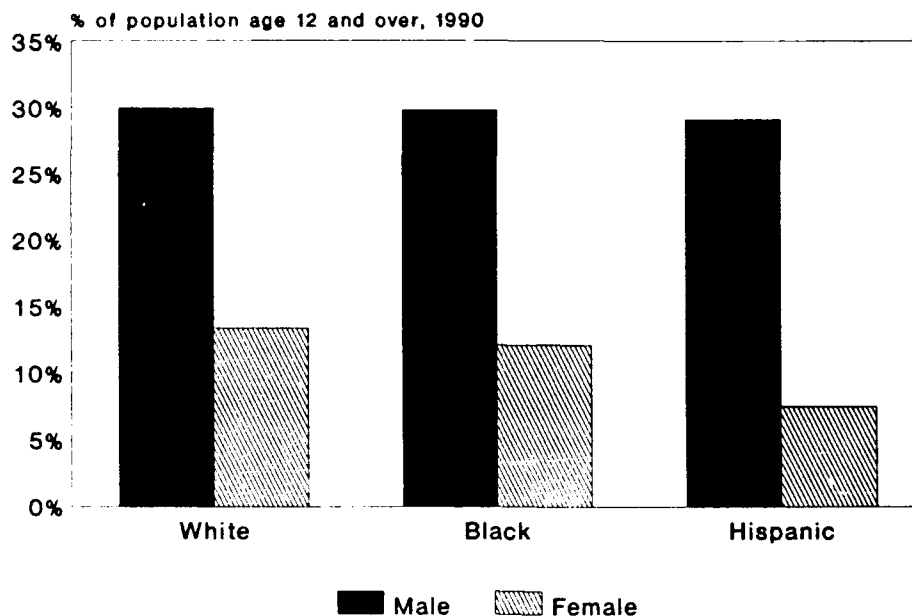


Figure 5. Racial/Ethnic Differences
By Sex -- Drink at Least Weekly

There is considerable cultural diversity among Hispanic groups. Mexican-American men and women had much higher rates of both abstention and heavier drinking than men and women of Puerto Rican or Cuban origin. Mexican-Americans also reported more alcohol-related problems than Puerto Ricans or Cubans.²⁷ Cuban Americans are far less likely to be heavy drinkers than either Mexican Americans or Puerto Ricans.²⁸ To the extent that Hispanics become assimilated into American society, their drinking patterns become more similar to the U.S. population at large.

Asian-Americans: Americans of Asian descent have the lowest level of alcohol consumption and alcohol-related problems of all the major racial and ethnic groups in the United States, but there are substantial differences between the various Asian cultures. A study of Californians of Chinese, Japanese, Korean and Filipino origin found that

Rates of abstention were very high among Korean men, nearly half of whom were abstainers. Approximately one-third of Chinese, Japanese, and Filipino men were abstainers. Four-fifths of Korean and Filipino women were abstainers, as were two-thirds of Chinese women but only one-third of

Japanese women.... Japanese, Korean and Filipino men all had approximately the same percentage of heavy drinkers (28%), but only half as many Chinese men drank heavily. Twelve percent of Japanese women drank heavily, but only 4% of Filipino women and virtually none of the Chinese or Korean women were heavy drinkers.²⁹

Although heavy drinking is prevalent among males in some Asian-American groups, there appear to be very few alcohol-related problems among Asian-Americans. This may be because the circumstances of drinking and the social controls are different for Asian-American cultures.

Native Americans: Drinking practices among American Indian tribal groups are so diverse that it is not possible to make generalizations about them. Some tribes are mostly abstinent while others have high levels of alcohol abuse.³⁰

Regional Differences

There are also regional differences in drinking practices, with the most alcohol per person consumed in the Northeast and the least in the South.

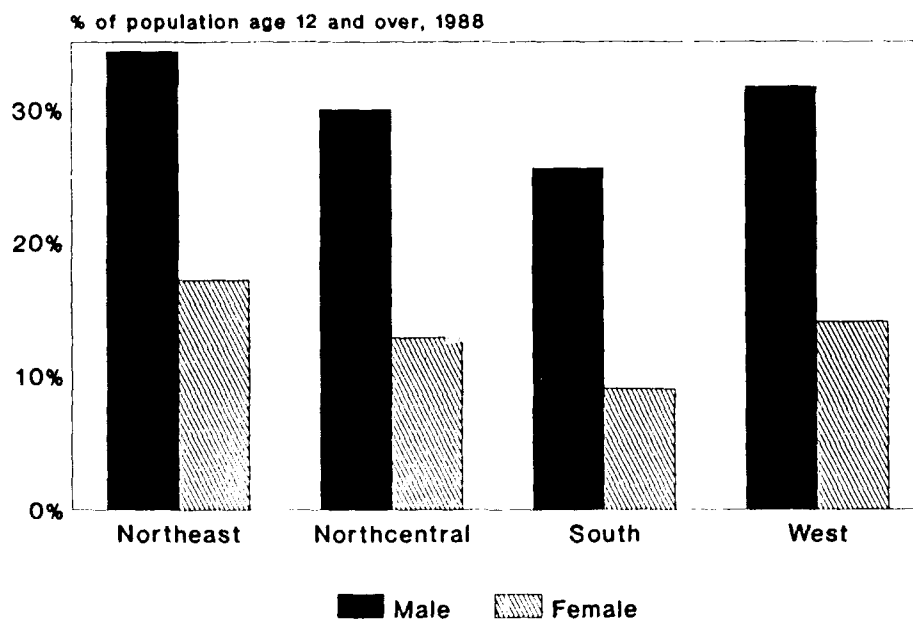


Figure 6. Regional Differences
By Sex -- Drink at Least Weekly

Figure 6 is based on the 1990 National Household Survey on Drug Abuse. It shows that in the Northeast over 34% of men and 17% of women drank alcohol at least

once a week during the year before the survey. Comparable figures for the South were only about 25% for men and a remarkably low 9% for women.

Other studies indicate that the entire southern tier of states, all the way across the country, has a much higher rate of abstinence than the northern states. These same southern states, however, also report significantly more alcohol-related problems than the northern states, particularly fighting, accidents, problems with police, and problems with friends or spouse. This could result from less tolerant attitudes prevalent in a relatively more abstinent social milieu.³¹

Indicators of Alcohol Abuse and Dependence

The most basic task of investigators and adjudicators is to determine whether information about an individual's past behavior meets specified standards for security clearance. Beyond that, however, investigators and adjudicators may also have to make inferences about things that are not clear from the file and to predict a person's *future* behavior pattern.

Making inferences about future behavior is always a risky business, but that is, after all, the purpose of the security clearance process. Our real interest is future behavior, how a person will behave if given a security clearance, not past behavior. Some elements of past behavior can serve as particularly useful guides to what one might expect in the future. This section identifies several indicators or predictors of future alcohol problems. The presence of these indicators in a specific case suggests that an individual may already have an alcohol problem or be at high risk for developing one. These indicators are certainly not conclusive evidence, but when present they do suggest a need for more careful investigation and analysis.

CAGE Test

A number of screening tests have been developed to identify persons who need further and more comprehensive assessment. One of these, the CAGE questionnaire, is so simple it can be administered inconspicuously during a routine interview. One first asks a neutral, lead-in question, such as "Do you drink now and then?" If the answer is affirmative, one then asks the following four questions: "Have you ever felt you should cut down on your drinking?" "Have people annoyed you by criticizing your drinking?" "Have you ever felt bad or guilty about your drinking?" "Have you ever had a drink first thing in the morning to steady your nerves or get rid of a hangover?"

A positive response to any one of these questions raises suspicions of a problem with alcohol use. More than one "yes" response is a strong indication that a problem exists and that an alcohol evaluation may be appropriate. On the other hand, all

negative responses is not necessarily conclusive if the interview is held under conditions that may motivate the subject to deny excessive alcohol use.³²

A recent study of 915 randomly selected patients admitted to the University of Michigan Hospital found that asking the four CAGE questions was a better predictor of alcohol dependence than lab tests. The CAGE questions correctly identified 87% of the patients, while a combination of lab tests had a predictive accuracy no greater than 50%.³³

Arrest for DWI

There are a large number of responsible citizens who occasionally drive with a blood alcohol level above the legal limit. In a recent U.S. national survey, 6.1% of adults responded positively when asked if they had driven during the past month "when you've had perhaps too much to drink."³⁴ In a 1983 Gallup Poll, 80% of mid-level executives of large companies answered yes when asked if they had ever driven while drunk; this compared with only 33% of the general public who reported they had ever driven while drunk.³⁵

Despite the reported prevalence of drinking and driving, actual arrest for driving while intoxicated (DWI)¹ is an important indicator of alcohol abuse. Most of those arrested for driving while intoxicated belong to that segment of the population that does have a serious drinking problem. They are not average citizens who just happen to have been caught during an unusual lapse in judgment or through an unfortunate piece of bad luck.

The approximately 2 million persons per year arrested for DWI represent a special category. People who are so drunk that their driving attracts attention and gets them arrested are usually problem drinkers. And since problem drinkers tend to drive under the influence repeatedly, they are the ones who push the odds to the point of getting caught.

Evidence of this comes from a systematic study of 1,600 military personnel arrested for DWI and who subsequently completed a five-day alcohol evaluation and education program at Beaumont Army Medical Center, Ft. Bliss, Texas.³⁶ This study showed that fully 90% of DWI offenders had a serious alcohol problem. Of this group, which represents all military personnel arrested for DWI either on or off post in the Ft. Bliss area from January 1985 to September 1989, 45% were diagnosed as alcohol dependent (alcoholic), 45% as alcohol abusers, and only 10% revealed no pattern of

¹Driving under the influence (DUI) is a more general term that refers to driving a motor vehicle under the influence of either alcohol or drugs. DWI applies only to intoxication by alcohol. Some state penal codes make this distinction while others do not, so the two terms are sometimes used interchangeably.

alcohol abuse, as shown in Figure 7. According to this study, a single DWI arrest indicates a 90% likelihood that the subject has an alcohol problem in need of treatment.

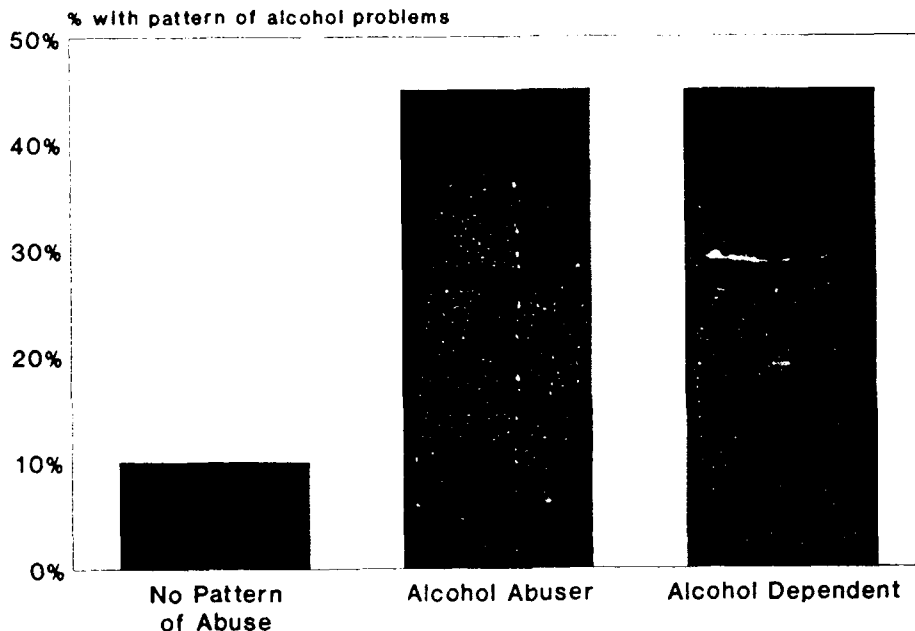


Figure 7. DWI Offenders -- Ft. Bliss Study

A civilian study of 1,208 persons convicted of driving under the influence in Indiana in 1985 reported almost identical findings--91.2% were diagnosed as alcohol abusers or alcohol dependent.³⁷ This percentage is higher than most previous studies of DWI offenders conducted in the 1960s and 1970s which generally found that 60% to 70% were alcohol dependent or alcohol abusers. The date of the studies may be a factor, as there has been a change in public attitudes concerning drinking and driving. Persons willing to drink and drive in the face of the greater social consciousness of its risks and punishments in the mid-80s are more likely to have a serious drinking problem than was the case in earlier years. The percentage will also depend upon the thoroughness of the post-arrest evaluation program. The depth of evaluation provided by the Ft. Bliss program was substantially greater than most other programs.

These findings have significant implications for investigators and adjudicators. Finding a record of a single DWI arrest should prompt investigators to intensify their search for other indications of alcohol-related problems. Adjudicators may wish to order an alcohol evaluation before approving a clearance. Some researchers have suggested that driving while impaired is often part of a more general behavioral syndrome typified

by high-risk behaviors and irresponsible attitudes,³⁸ and this could be checked through professional medical evaluation.

Information is available from the Department of Justice on the amount and type of alcohol consumed by DWI offenders who were in jail during 1983. This may be of interest for comparison purposes.

The median blood alcohol level at time of arrest was .20, which means half of those arrested had levels above that figure and half below. The median prisoner had been drinking for four hours prior to arrest and had consumed 6 ounces of pure alcohol, which is the equivalent of 12 beers or 8 mixed drinks. Some (9%) had consumed as little as two ounces of pure alcohol. Those who had consumed the least pure alcohol prior to their arrest reported that they generally drank daily or several times per week. Those who consumed the most--10 ounces or more--reported that this was their normal consumption when drinking, but nearly half said their frequency of drinking was less than weekly. This type of binge drinking is thought to be most common among younger age groups and among those not living with spouses.

Only beer had been consumed by 54%, while 21% had been drinking only liquor, 2% only wine, and 21% more than one type of alcoholic beverage. The beer drinkers consumed the smallest amount of pure alcohol. Those who combined different beverages were estimated to have consumed more than three times as much pure alcohol as those who drank beer only, and nearly 40% more than those who drank liquor only.

These figures are not necessarily representative of all DWI offenders. They are for offenders sentenced to jail, while most DWI offenders are sentenced to probation or receive other sanctions. Considerable additional detail is available in the full report.³⁹

Circumstances of Alcohol Use

Motivation for using alcohol or any other drug is one of the most potent predictors of future use or problems with that drug. If the motivation is experimentation, peer pressure, or adolescent rebelliousness, this is not indicative of future abuse. To the extent that alcohol is used as a means of coping with life's problems, such as stress or low self-esteem, then one can expect that the drinking itself will eventually become a source of future problems. Similarly, if heavy alcohol consumption is incorporated into one's lifestyle, this also indicates a high likelihood of future problems.⁴⁰

In this context, solitary drinking until intoxicated is far more predictive of future problems than social drinking. So is drinking *prior* to social events (to relax), as compared with alcohol use *at* social events. If drinking becomes a compulsive daily ritual, followed the same time each day, this indicates future problems as it suggests that

one's life has become centered around the drug. Regular morning drinking as an "eye-opener" or to overcome a hangover is a strong indicator of alcohol dependence.⁴¹

Peak alcohol use normally occurs in white youths during the late high school or college years. If peak use continues after college, or after about age 23, this is atypical and suggests future problems. Blacks and Hispanics commonly reach peak use in their late 20s or early 30s.

Alcoholic Parent

There is a wealth of evidence that one of the greatest risk factors for becoming an alcoholic is to be the son, daughter, brother, or sister of one. Although the evidence is clear, the reasons for it are not; so far, scientists have been unable to determine whether the family nature of alcoholism is best explained by inherited or environmental factors.

The evidence suggests that the child of an alcoholic is about two to five times more likely to become an alcoholic than a child with no family history of alcoholism. The chances the child will follow in the parent's footsteps depend, in part, upon which parent is the alcoholic and the nature of the relationship with that parent. Children of alcoholic mothers are at far greater risk than children of alcoholic fathers. Sons of alcoholic fathers are almost twice as likely to become alcoholics if the mother expressed high esteem for her alcoholic husband than if she did not convey to her children a high regard for their father.⁴²

Tolerance for Alcohol

One characteristic of alcohol dependence is increasing tolerance for alcohol--it takes more and more to have the same affect on the body. Heavy drinkers who may not otherwise admit to an alcohol problem may nonetheless boast of their high tolerance level. "I can drink a lot without its having any affect on me, so I don't have to worry." Such tolerance is by no means conclusive evidence of alcohol dependence, but it should be interpreted as a warning indicator. Increasing severity of dependence is marked by the individual functioning at a blood alcohol level that would incapacitate the less tolerant drinker.

Relationship of Alcohol to Other Problem Behavior

Problems in handling alcohol are often observed in combination with other security and suitability issues, and they take on greater significance in these cases. If alcohol is the only problem, a motivated employee can generally kick the habit or bring it

under control. When combined with other issues, alcohol may be part of a broader behavior pattern that is much harder to change and may justify denial of clearance.

Patterns of high-risk and irresponsible behavior, and aggressive antisocial behavior, are the most common. In addition to alcohol problems, actions consistent with these behavior patterns include drug abuse, borrowing money without the ability to repay, spouse abuse, theft, shoplifting, fighting, multiple sex partners in the age of AIDS, as well as espionage.

The association between alcohol and some other behaviors discussed in this section is so close that existence of an alcohol problem should be viewed as an indicator that other problems may be present as well. This should guide security personnel toward heightened awareness and more thorough investigation in cases where alcohol problems are apparent.

Alcohol and Mental/Emotional Disorders

One study found that within the general population, nearly half of all those diagnosed as alcohol abusers or alcohol dependent also had some form of psychiatric disorder. The percentage was greater for females than males. "Although the diagnosis of alcohol dependence was five times more prevalent among men than among women, the association of alcoholism with other [psychiatric] diagnoses was stronger in women; 65% of female alcoholics had a second diagnosis, compared with 44% of male alcoholics."⁴³

A different study that examined only those in treatment for both alcohol and other drug problems found that 65% had a current mental disorder and 78% had a history of some mental disorder during their lifetime. The patients in treatment for alcoholism had lifetime prevalence rates of 42% for antisocial personality disorder, 31% for phobias, 30% for psychosexual dysfunction, 23% for major depression, 13% for dysthymia (a depressive disorder), 9% for panic disorder, and 8% for schizophrenia. Obviously, many patients had more than one disorder. The diagnostic methods used may have led to overestimation in some categories, but the findings are nonetheless significant.⁴⁴

Characteristics of antisocial personality disorder include inability to sustain consistent employment, impulsiveness, recklessness, irritability, aggressiveness, failure to honor financial obligations, and inability to maintain enduring relationships or function as responsible parents.⁴⁵

Alcohol and Crime

The relationship between alcohol and crime in the general population is unclear. What appears on the surface to be a close relationship may be inflated by several factors, including the fact that alcohol abuse and crime are both prevalent among the same demographic group--young men. A direct causal relationship between alcohol and crime has not been established. One study found that by age 31 there was no significant relationship between alcohol consumption and crime.⁴⁶

The previously discussed studies at Ft. Bliss, on the other hand, showed a strong relationship between DWI offenses and criminal activity. Figure 8 illustrates the relationship between DWI offenses and several types of illegal behavior. It shows the percentage of military personnel with no arrest for DWI, with one offense, and multiple offenses who then engaged in three different forms of illegal activity. On the graph,

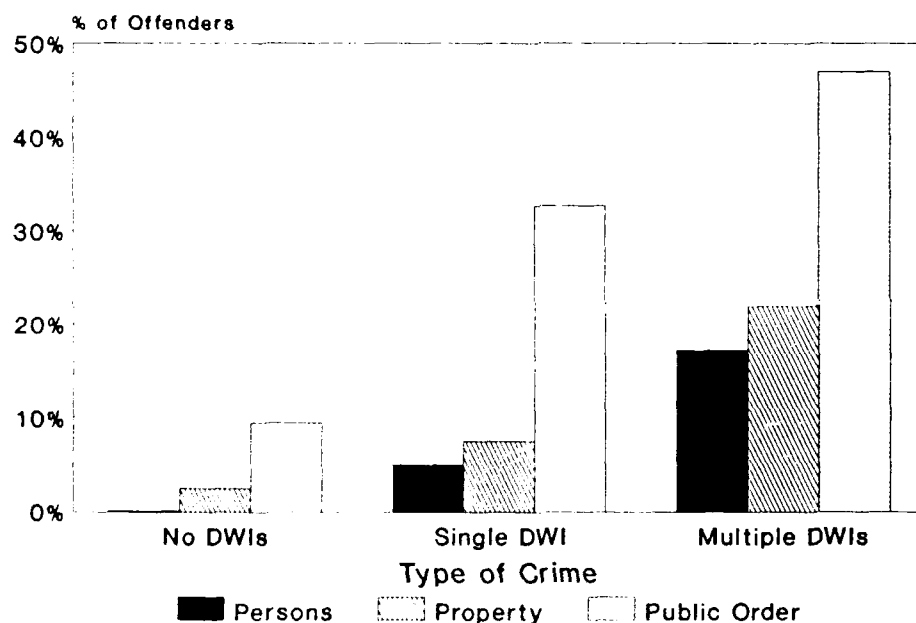


Figure 8. DWI and Crime -- Ft. Bliss Study

persons refers to crimes against persons, such as assault, child or spouse abuse, or attempted murder. Property refers to property crimes such as larceny and damage to government property, while public order refers to disorderly conduct, domestic disturbance, or AWOL. As seen in this graph, those with one DWI offense were several times more likely to engage in other illegal activity than those with no prior DWI record,

while those with multiple DWI offenses were about twice as likely to engage in objectionable behaviors as those with only one DWI offense.

This strong relationship between alcohol and crime in the Ft. Bliss population may not be as strong in an applicant pool that is probably a little older, better educated, and lacking some of the personality characteristics that lead one to volunteer for military service.

Alcohol and Spouse Abuse

The Ft. Bliss study supports studies of civilian populations that show alcoholism and alcohol abuse is related to 50% to 75% of spouse abuse incidents. Surprisingly, the spousal violence generally does not occur during or immediately after the drinking; as a result, the drunkenness is often not reported in police reports on the spouse abuse. However, so many spouse abusers have alcohol problems that spouse abuse may be regarded as a possible indicator of alcohol problems. The Ft. Bliss study recommends that, within a military community, all spouse abusers be referred for alcohol evaluation.

Mitigating Factors

Treatment Effectiveness

If an individual has obtained or is seeking help for an alcohol problem, this may be considered as a mitigating factor for past alcohol abuse. During the 12 months ending October 31, 1987, 1.43 million persons were treated in 5,586 treatment centers in the United States. Of these, 76.3% were male; 71.5% were white, 15.4% black, and 9.9% Hispanic; and 55% were between the ages of 25 and 44 years old.⁴⁷

A number of questions arise when evaluating individual cases. What are the chances that a recently completed treatment for alcoholism will be successful? How long must an individual be abstinent before security adjudicators may have reasonable confidence that the problem will not recur? What is the significance of one or two relapses? Fortunately, some hard evidence is available to answer these questions.

A very interesting study of treatment outcomes was conducted by the Tri-Service Alcoholism Recovery Department (TRISARD) at the Bethesda Naval Hospital.⁴⁸ The TRISARD study followed 722 patients for two years after they completed a six-week inpatient alcoholism treatment program. The outcome of the treatment was measured by clinical reports from aftercare personnel as well as by supervisors' reports on job performance. Such objective measurement of treatment "success" distinguishes this study from many others that judge success only by the patients' own reports of treatment effectiveness.

The study found that 77% of the patients who completed the inpatient program succeeded in continuous abstinence from alcohol during the two-year study period. Supervisors reported satisfactory job performance during the study period for 90% of those who completed the program. Percentage of success was greater for those patients who were higher in rank, older, had been in the service longer, and--most important--those who adhered to the one-year-long aftercare program.

Of those who completed the inpatient program and complied with the aftercare program, 97% were successful by all measures at the end of the two-year study period. Of those who failed for any reason to complete the six-week inpatient program, 63% nevertheless met all the criteria for long-term treatment success.

Most civilian programs would probably not be as successful as the TRISARD program. Patients in this program were strongly motivated, as they all had a large investment in their jobs and participation in the program was a condition of continued employment. Those conditions do not apply to most civilian programs. The authors conclude that the results may apply

to large occupational programs that serve stable, hierarchical work forces such as large manufacturing concerns, civilian uniformed employees, and local, state, and federal workers. They apply to any setting where the participation of the worker in treatment is a condition of continued employment, the worker is strongly vested, and the social and occupational status of the worker may be clearly defined.

There is great variety in the length and types of treatments used in civilian alcoholism treatment programs, and the length of aftercare programs varies from one to three months up to two years. The scientific evidence of the effectiveness of many treatments is questionable, but all programs have many graduates who report successful outcomes. The evidence indicates that expensive, inpatient treatment programs offer no advantages in overall effectiveness as compared with outpatient treatment.⁴⁹ It may be that the effectiveness of treatment is determined more by the motivation of the participant to break the habit than by the specifics of the treatment program.

For many persons, formal treatment may be unnecessary. Spontaneous remission of drinking problems is common as drinkers move into older age categories and the lifestyle, stress or other circumstances that prompted the drinking change. One survey rechecked the same respondents nine years later. It found that of those reporting drinking problems during the first questioning, fewer than half reported still having problems at the time of the follow-up questioning.⁵⁰ The likelihood of spontaneous remission without treatment is relatively high among young men in their 20s, but relatively low among older men in their 40s.⁵¹ Controlling one's own drinking problem without treatment is far more common in women than among men.⁵²

For the adjudicator evaluating the significance of alcoholism treatment as a mitigating factor, the most significant indicators that an individual will remain abstinent are successful completion of the treatment program, strict adherence to the aftercare program, and any other evidence that the individual recognizes his or her problem and is highly motivated to overcome it.

Relapse Rates

Relapse is a common occurrence after all addiction treatment programs, but the risk of relapse diminishes as time passes. In alcohol as well as drug and smoking addiction programs, the first relapse occurs most commonly during the first three months after completion of treatment.⁵³ If one gets through the first three months without relapse, the chances for long-term abstinence improve dramatically, and the chances of a relapse that affects work performance are very small, according to the TRISARD study.

Figures 9 and 10 illustrate the relapse rate for graduates of the TRISARD program. Figure 9 represents all graduates of the program, while Figure 10 deals only with those who failed to complete the aftercare program and who, therefore, in most cases failed to maintain abstinence. The most interesting part of Figure 10 is that it shows how soon that failure occurred and what its consequences were for behavior and job performance.

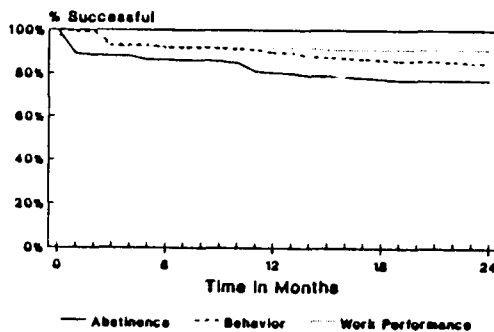


Figure 9. Relapse Rate Over Time
All TRISARD Graduates

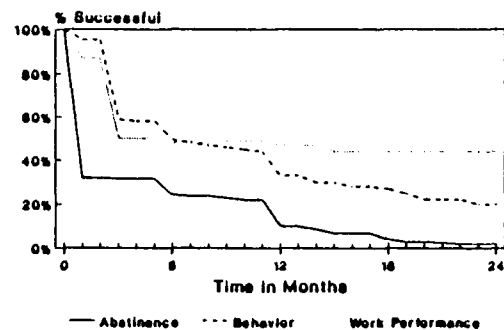


Figure 10. Relapse Rate Over Time
Graduates Who Failed Complete Aftercare

The charts show three different measures of success: abstinence refers to total abstinence after completion of the treatment; behavior refers to success in avoiding alcohol-related behavioral incidents; successful work performance was judged by a periodic questionnaire filled out by the patient's job supervisor.

It is noteworthy that failure to achieve complete abstinence did not, in most cases, lead to objectionable behavior or affect work performance. In fact, this study showed that when a patient who completed the program got through three months without a relapse, the chance that any subsequent relapse from abstinence would affect job performance was almost negligible for at least 24 months. This is illustrated by the nearly straight dotted line on both charts. It must be remembered, however, that this favorable outcome was achieved with a group of patients with a large investment in their job and who risked separation from the service if the treatment was unsuccessful. Only under similar circumstances might adjudicators be confident that three months of abstinence after treatment would be adequate for a finding of mitigating circumstances.

Conclusions

Alcohol abuse and alcoholism have been the subject of extensive study. Much good information is available that is relevant to personnel security decisions and the process for making these decisions. Some of this information helps policy-makers set standards. Other information helps investigators decide when to expand an investigation or adjudicators to understand the significance of information in a case file.

Among the more interesting and useful points are the differences between alcohol abuse and alcohol dependence (alcoholism); the utility of the simple, four-question CAGE test for identifying individuals who may have an alcohol problem; the potential significance of a single DWI offense or of growing up with an alcoholic parent; the high frequency with which alcohol problems are associated with other problem behaviors; and that the risk of relapse after treatment is perhaps less of a concern than is sometimes believed.

Appendix - Adjudication Criteria

Adjudication criteria are set forth in Director of Central Intelligence Directive No. 1/14, "Minimum Personnel Security Standards and Procedures," dated 14 April 1986. These are the guidelines used by the Central Intelligence Agency, while the Department of Defense has supplemented the DCID 1/14 guidelines with more specific standards in DoD 5200.2-R. The Defense Department adjudication standards for alcohol use are in the process of being revised. The following paragraphs provide direct quotes from the DCID 1/14 guidelines and the more specific DoD 5200.2-R standards (revised version now undergoing final review).

DCID 1/14 Alcohol Guidelines

The SCI adjudicator should examine any information developed relative to an individual's use of alcoholic beverages to determine the extent to which such use would adversely affect the ability of the individual to exercise the care, judgment, and discretion necessary to protect SCI information. The adjudicator should determine whether a pattern of impropriety exists, although one incident caused by alcohol abuse may be of such magnitude to warrant a recommendation for disapproval.

In determining the security impact of a person's pattern of alcohol use, the adjudicator should consider the circumstances, amount and rate of consumption, the time and place of consumption, and the physiological and behavioral effect such drinking has on the individual. For example, does the individual's drinking result in absences from work or careless work habits? Does the individual become talkative, abusive, or manifest other undesirable characteristics? Does the individual drink until intoxicated? Has the individual been arrested for any acts resulting from the influence of alcohol?

In the absence of conclusive evidence, additional insight may be available from appropriate medical authorities. If the individual acknowledges having an alcohol abuse problem and is seeking help, it may be appropriate to defer access determination and monitor the individual's progress for a year or so.

If, after considering the nature and sources of the information, the adjudicator determines that an individual's drinking is not serious enough to warrant a recommendation for disapproval of SCI access, it may be appropriate to recommend approval with a warning at the time of indoctrination that future incidents of alcohol abuse may result in SCI denial. The adjudicator may also recommend a reinvestigation of the individual's use of alcohol after an appropriate period of time has passed.

DoD 5200.2-R Alcohol Standards

The following revised alcohol standards are now undergoing final review for adoption by the Department of Defense to supplement the criteria in DCID 1/14.

Basis: Diagnosis or other evidence indicating alcohol abuse or alcoholism, including habitual or episodic use of alcohol to excess.

GENERAL NOTE: Behavior may include, but is not limited to, one or more of the following potentially disqualifying factors:

Potentially Disqualifying Factor 1. Diagnosis of alcoholism/alcohol dependence by a credentialed authority (psychiatrist, physician, or clinical psychologist).

Mitigating Factor 1. Successful subsequent completion of an alcohol treatment program including:

- a. successful completion of an initial inpatient or outpatient rehabilitation phase, and
- b. after the rehabilitation phase, strict compliance with and completion of aftercare requirements, and
- c. regular and frequent participation in meetings of Alcoholics Anonymous or a similar organization, and
- d. total abstention from alcohol, and
- e. a 1-year period since completion of initial rehabilitation and, if feasible to obtain, a favorable prognosis by a credentialed authority.

Specific Note Regarding Mitigating Factor 1e. Central adjudication facilities have the choice whether or not to grant interim access or a conditional clearance after successful completion of the initial rehabilitation phase with a favorable prognosis by a credentialed authority. If interim access or a conditional clearance is granted, there should be three consecutive months of successfully meeting the aftercare requirements to include total abstinence. Also, any subsequent use of alcohol after this granting of interim access or conditional clearance must result in immediate suspension of access pending completion of the above 1-year period and final adjudication.

Potentially Disqualifying Factor 2. Participation in an alcohol rehabilitation and aftercare program (not to include alcohol awareness and education programs) with subsequent on- or off-job alcohol-related incidents.

Mitigating Factor 2. Successful subsequent completion of an alcohol treatment program including:

- a. successful completion of an initial inpatient or outpatient rehabilitation program, and
- b. after the initial rehabilitation phase, strict compliance with and completion of aftercare requirements, and
- c. regular and frequent participation in meetings of Alcoholics Anonymous or a similar organization, and
- d. total abstention from alcohol, and
- e. a 2-year period since completion of initial rehabilitation and, if feasible to obtain, a favorable prognosis by a credentialed authority.

Specific Note Regarding Mitigating Factor 2e. Adjudication facilities cannot grant interim access or a conditional clearance in these cases.

Potentially Disqualifying Factor 3. Diagnosis of alcohol abuse by a credentialed authority.

Mitigating Factor 3. Subsequent compliance with medical, counseling, or professional advice, including:

- a. evidence of significantly reduced alcohol consumption for six months (if feasible, followed by a favorable prognosis by a credentialed authority), and
- b. positive changes in life-style supportive of sobriety and, where relevant, improvements in job reliability, or
- c. initial determination of a favorable prognosis by a credentialed authority.

Potentially Disqualifying Factor 4. Evidence from other than credentialed authority indicating habitual or episodic consumption of alcohol to the point of impairment or intoxication.

Mitigating Factor 4a. After subsequent referral by the adjudication facility, the diagnosis by credentialed authority is that the individual is not an alcohol abuser or an alcoholic/alcoholic dependent, or

Mitigating Factor 4b. If the new diagnosis by credentialed authority indicates the individual is an alcoholic/alcohol dependent, or an alcohol abuser, see Mitigating Factors 1 and 3, or

Mitigating Factor 4c. If there is no new diagnosis by credentialed authority, there should be:

- (1) reliable evidence of significantly reduced alcohol consumption for two years, and
- (2) positive changes in life-style supportive of sobriety and, where relevant, improvements in job reliability.

Potentially Disqualifying Factor 5. Alcohol-related incidents away from work, such as driving while under the influence, fighting, child or spouse abuse, or other criminal incidents related to alcohol consumption or alcohol-related incidents at work, such as reporting for work or duty in an intoxicated or impaired condition, or drinking on the job.

Mitigating Factor 5a. After subsequent referral by the adjudication facility, the diagnosis by credentialed authority is that the individual is not an alcohol abuser or an alcoholic/alcohol dependent, or

Mitigating Factor 5b. If the new diagnosis by credentialed authority indicates the individual is an alcoholic/alcohol dependent or an alcohol abuser, see Mitigating Factors 1 and 3, or

Mitigating Factor 5c. Reliable evidence of significantly reduced alcohol consumption or abstinence for two years and positive changes in life-style supportive of sobriety and, where relevant, improvements in job reliability, and

Mitigating Factor 5d. No alcohol incidents away from work in the last two years and no job-related incidents in the last five years.

Note Regarding Mitigating Factor 5. If feasible, central adjudication facilities should request an evaluation for alcohol abuse/alcoholism/alcohol dependence if two or more of these incidents resulted in arrest and formal charges by military or civilian police during the last five years.

References

1. Carney, R. M. (1991, April). *Evaluation of DCID 1/14 investigative requirements*. Washington, DC: CIA, IC Staff, Personnel Security Working Group.
2. Waller, F. P. (1986). Alcohol and unintentional injury. In B. Kissin and H. Begleiter (Eds.), *Encyclopedic Handbook of Alcoholism* (pp. 395-405). New York: Gardner Press.
3. Alcoholics Anonymous. *Alcoholics Anonymous 1989 Membership Survey*.
4. National Institute on Alcohol Abuse and Alcoholism (NIAAA). (1990, January). *Seventh Special Report to the U.S. Congress on Alcohol and Health* (pp. 165 and 171). Washington, DC: Author.
5. Harwood, H. J., Kristiansen, P., & Rachal, J. V. (1985). *Social and economic costs of alcohol abuse and alcoholism* (Issue Report No. 2). Research Triangle Park, NC: Research Triangle Institute. (From NIAAA, *op. cit.*, p. 174).
6. NIAAA, *op. cit.*, p. vii.
7. National Institute of Alcohol Abuse and Alcoholism. (1989, May). Alcohol and cognition. *Alcohol Alert*, 4.
8. National Institute on Drug Abuse. (1990). *National Household Survey on Drug Abuse: Population Estimates*. Washington, DC: Author.
9. NIAAA, *op. cit.*, p. ix.
10. NIAAA, *op. cit.*, p. xviii.
11. NIAAA, *op. cit.*, pp. xviii and 184.
12. NIAAA, *op. cit.*, pp. 13-15.
13. NIAAA, *op. cit.*, pp. 13-15.
14. Malin, H., Wilson, R., Williams, G., & Aitken, S. (1986). 1983 health practices supplement. Epidemiologic bulletin no. 10. *Alcohol Health and Research World*, 10(2), 48-50.
15. NIAAA, *op. cit.*, p. 13.

16. Johnson, L. D., O'Malley, P. M. & Bachman, J. G. (1988). *Illicit drug use, smoking and drinking by america's high school students, college students, and young adults, 1975-1987*. (Dept. of Health and Human Services Pub. No. (ADM)89-1602). Rockville, MD: ADAMHA. (From NIAAA, *op. cit.*, p. 28).
17. Johnson, L. C., O'Malley, P. M., & Bachman, J. G. (1989). *Drug use, drinking, and smoking: National survey results from high school, college and young adult populations, 1975-1988*. (Dept. of Health and Human Services Pub. No. (ADM)89-1638). Rockville, MD: ADAMHA. (From NIAAA, *op. cit.*, p. 28).
18. Temple, M. T., & Fillmore, K. M. (1985-86). The variability of drinking patterns and problems among young men, age 16-31: A longitudinal study. *International Journal of Addiction*, 20, 1595-1620. (From NIAAA, *op. cit.*, p. 29)ADAMHA. (From NIAAA, *op. cit.*, p. 27.).
19. Hilton, M. E. (1987). Drinking patterns and drinking problems in 1984: Results from a general population survey. *Alcoholism*, 11, 167-175. (From NIAAA, *op. cit.*, p. 23).
20. Fillmore, K. M. (1987). Women's drinking across the adult life course as compared to men's. *British Journal of Addiction*, 82, 801-811. (From NIAAA, *op. cit.*, p. 24.).
21. Wilsnack, R. W., Wilsnack, S. C., & Klassen, A. (1984). Women's drinking and drinking problems: Patterns from a 1981 national survey. *American Journal of Public Health*, 74, 1231-1238. (From NIAAA, *op. cit.*, p. 20).
22. Whitehead, P. C., & Layne, N. (1987). Young female Canadian drinkers: Employment, marital status and heavy drinking. *British Journal of Addiction*, 82, 169-174. (From NIAAA, *op. cit.*, p. 29).
23. Wilsnack, R. W., *et al.*, *op. cit.*, and related studies. (From NIAAA, *op. cit.*, p. 25).
24. Wilsnack, R. W., & Cheloha, R. (1987). Women's roles and problem drinking across the lifespan. *Social Problems*, 34, 231-248. (From NIAAA, *op. cit.*, p. 25).
25. Herd, D. (1989). The epidemiology of drinking patterns and alcohol-related problems among U.S. blacks. In National Institute for Alcohol and Alcohol Abuse, *The epidemiology of alcohol use and abuse among U.S. minorities*. (NIAAA Monograph No. 18, Dept. of Health and Human Services Pub. No. (ADM)89-1435.) Washington, DC, U.S. Government Printing Office. (From NIAAA, *op. cit.*, p. 33).
26. *Ibid.*

27. Caetano, R. (1988). Alcohol use among hispanic groups in the United States. *American Journal of Drug and Alcohol Abuse*, 14, 293-308. (From NIAAA, *op. cit.*, p. 34.).
28. National Clearinghouse for Alcohol and Drug Information. (January 1989). Alcohol and other drug use in three hispanic populations: Mexican-Americans, Puerto Ricans, and Cuban-Americans. *NCADI Update*.
29. Kitano, H. H. L., & Chi, I. (1986-87). Asian-Americans and alcohol use. *Alcohol Health and Research World*, 11(2), 42-47. (From NIAAA, *op. cit.*, p. 35).
30. NIAAA, *op. cit.*, p. 36.
31. Hilton, M. E. (1988). Regional diversity in United States drinking practices. *British Journal of Addiction*, 83, 519-532. (From NIAAA, *op. cit.*, pp. 15 and 19).
32. Ewing, J. A. (1984). Detecting alcoholism, the CAGE questionnaire. *Journal of the American Medical Association*, 252, 1905-1907. (From NIAAA, *op. cit.*, p. 187).
33. Beresford, T. P., Blow, F. C., Singer, K., Hill, E., & Lucey, M. R. (1990, August 25). Using the CAGE questionnaire to screen for alcoholism. *Lancet*. Reported in Business Research Publications (1990, November 1), *Substance Abuse Report*, 21(21).
34. Bradstock, M. K., Marks, J. S., Forman, M. R., Gentry, E. M., Hogelin, G. C., Binkin, N. J., & Trowbridge, F. L. (1987). Drinking-driving and health lifestyle in the United States: Behavioral risk factors survey. *Journal of Studies on Alcohol*, 48, 147-152. (From NIAAA, *op. cit.*, p. 164).
35. Examining ethics. (December 1983/January 1984). *Public Opinion*, p. 40.
36. Kruzich, D. J., Silsby, H. D., Gold, J. D., & Hawkins, M. R. (1986). An evaluation and education program for driving while intoxicated offenders. *Journal of Substance Abuse Treatment*, 3, 263-270. Initial data in this study were updated in personal communication from Jack Gold to Kent Crawford, PERSEREC, November 1990.
37. Crancer, A. (1986). The myth of the social drinker-DUI driver. Paper presented at the Joint Meeting of the American Medical Society on Alcoholism and Other Drug Dependencies and the Research Society on Alcoholism, San Francisco, CA.
38. Wilson, R. J., & Jonah, B. A. (1985). Identifying impaired drivers among the general driving population. *Journal of Studies on Alcohol*, 46(6), 531-537.
39. Greenfield, L. A. (1988). Drunk driving. (Bureau of Justice Statistics Special Report RPO722) Washington, DC: U.S. Department of Justice.

40. Glantz, M. Prevention Branch, Division of Clinical Research, National Institute on Drug Abuse. (Personal communication, April 1991.)
41. *Ibid.*
42. El-Guebaly, N., & Offord, D. R. (1979). On being the offspring of an alcoholic: An update. *Alcoholism (NY)*, 3, 148-157; Werner, E. E. (1986). Resilient offspring of alcoholics: A longitudinal study from birth to age 18. *Journal of Studies of Alcohol*, 47(1), 34-40; McCord, J. (1988) Identifying developmental paradigms leading to alcoholism. *Journal of Studies of Alcohol*, 49, 357-362. (All from NIAAA, *op. cit.*, p. 56).
43. Helzer, J., & Pryzbeck, T. R. (1988). The co-occurrence of alcoholism with other psychiatric disorders in the general population and its impact on treatment. *Journal of Studies of Alcohol*, 49(3), 219-224. (From NIAAA, *op. cit.*, pp. 21-22) NIAAA, *op. cit.*, p. 56).
44. Ross, H. E., Glaser, F. B., & Germanson, T. (1988). The prevalence of psychiatric disorders in patients with alcohol and other drug problems. *Archives of General Psychiatry*, 45, 1023-1031.
45. NIAAA, *op. cit.*, p. 196.
46. Temple, M., & Ladouceur, P. (1986). The alcohol-crime relationship as an age-specific phenomenon: A longitudinal study. *Contemporary Drug Problems*, 13(1), 89-116. (From NIAAA, *op. cit.*, pp. 171-172).
47. National Institute for Drug Abuse. (1989). *Highlights from the 1987 national drug and alcoholism treatment unit survey (NDATUS)*. Rockville, MD: NIDA/NIAAA. (From NIAAA, *op. cit.*, p. 261).
48. Wright, C., Grodin, D. M., & Harig, P.T. (1990). Occupational outcome after military treatment for alcoholism. *Journal of Occupational Medicine*, 32(1), 24-32.
49. Miller, W. R., & Hester, R. K. (1986). The effectiveness of alcoholism treatment: What research reveals. In W.R. Miller and N. Heather (Eds.), *Treating addictive behaviors: Processes of change* (pp. 121-174). New York: Plenum Press.
50. Hermos, J. A., LoCastro, J. S., Glynn, R. J., Bouchard, G. R., & De Labry, L. O. (1988). Predictors of reduction and cessation of drinking in community-dwelling men: Results from the normative aging study. *Journal of Studies on Alcohol*, 49, 363-368. (From NIAAA, *op. cit.*, p. 24).

51. Fillmore, K., & Midanik, L. (1984). Chronicity of drinking problems among men: A longitudinal study. *Journal of Studies on Alcohol*, 45(3).
52. Fillmore, K. (1987). Women's drinking across the adult life course as compared to men's. *British Journal of Addiction*, 82, 801-811. (From NIAAA, *op. cit.*, p. 24)
53. Hunt, W. A., Barnett, L. W., & Branch, L. G. Relapse rates in addiction programs. Additional identifying data not available.